BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
Larry David Resneck-Sannes, M.D.	)	**Case No. 03-2012-222584**
Physician's and Surgeon's Certificate No. G 25952	)	
Respondent	)	

DECISION

The attached Stipulated Settlement and Disciplinary Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on November 6, 2015.

IT IS SO ORDERED: October 8, 2015.

MEDICAL BOARD OF CALIFORNIA

Dev Gnanadev, Chair
Panel B

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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **LARRY DAVID RESNECK-SANNES, M.D.** 5403 Scotts Valley Drive #A Scotts Valley, CA 95066 **Physician's and Surgeon's Certificate No. G25952** Respondent.	Case No. 03-2012-222584 OAH No. 2015060764 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. Kimberly Kirchmeyer ("Complainant") is the Executive Director of the Medical Board of California. She brought this action solely in her official capacity and is represented in this matter by Kamala D. Harris, Attorney General of the State of California, by Emily L. Brinkman, Deputy Attorney General.

2. Respondent Larry David Resneck-Sannes, M.D. ("Respondent") is represented in this proceeding by attorney Thomas E. Still, whose address is: 12901 Saratoga Avenue, Saratoga, CA 95070-9988.

3. On or about November 1, 1973, the Medical Board of California issued Physician's and Surgeon's Certificate No. G25952 to Larry David Resneck-Sannes, M.D. (Respondent). The

Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 03-2012-222584 and will expire on July 31, 2017, unless renewed.

JURISDICTION

4. Accusation No. 03-2012-222584 was filed before the Medical Board of California (Board), Department of Consumer Affairs, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on June 5, 2014. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 03-2012-222584 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 03-2012-222584. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

7. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to be represented by counsel at his own expense; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

8. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

9. Respondent does not contest that, at an administrative hearing, complainant could establish a prima facie case with respect to the charges and allegations contained in Accusation

No. 03-2012-222584 and that he has thereby subjected his Physician's and Surgeon's Certificate No. G25952 to disciplinary action.

10. Respondent agrees that his Physician's and Surgeon's Certificate is subject to discipline and he agrees to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

11. Respondent agrees that if he ever petitions for early termination or modification of probation, or if an accusation and/or petition to revoke probation is filed against him before the Board, all of the charges and allegations contained in Accusation No. 03-2012-222584 shall be deemed true, correct and fully admitted by Respondent for purposes of that proceeding.

CONTINGENCY

12. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

13. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Settlement and Disciplinary Order, including Portable Document Format (PDF) and facsimile signatures thereto, shall have the same force and effect as the originals.

14. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G25952 issued

to Respondent Larry David Resneck-Sannes, M.D. (Respondent) is revoked. However, the revocation is stayed and Respondent is placed on probation for five (5) years on the following terms and conditions.

1. EDUCATION COURSE. Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for the first two years of probation, and then reduced by ten hours each year of probation thereafter. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition for the first two years of probation and then reduced by ten hours for each subsequent year of probation.

2. CLINICAL TRAINING PROGRAM. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a clinical training or educational program equivalent to the Physician Assessment and Clinical Education Program (PACE) offered at the University of California - San Diego School of Medicine ("Program"). Respondent shall successfully complete the Program not later than six (6) months after Respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The Program shall consist of a Comprehensive Assessment program comprised of a two-day assessment of Respondent's physical and mental health; basic clinical and communication skills common to all clinicians; and medical knowledge, skill and judgment pertaining to Respondent's area of practice in which Respondent was alleged to be deficient, and at minimum, a 40 hour program of clinical education in the area of practice in which Respondent was alleged to be deficient and which takes into account data obtained from the assessment, Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant.

Respondent shall pay all expenses associated with the clinical training program.

Based on Respondent's performance and test results in the assessment and clinical education, the Program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, treatment for any medical condition, treatment for any psychological condition, or anything else affecting Respondent's practice of medicine. Respondent shall comply with Program recommendations.

At the completion of any additional educational or clinical training, Respondent shall submit to and pass an examination. Determination as to whether Respondent successfully completed the examination or successfully completed the program is solely within the program's jurisdiction.

If Respondent fails to enroll, participate in, or successfully complete the clinical training program within the designated time period, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The Respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical training program have been completed. If the Respondent did not successfully complete the clinical training program, the Respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.

3. MONITORING - PRACTICE. Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice monitor(s), the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, Respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine, and whether Respondent is practicing medicine safely, billing appropriately or both. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3)

calendar days after being so notified Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

The Practice Monitor shall monitor Respondent's practice for the first three years of probation. At the end of the three year period, the Monitor will be required to submit a final written report evaluating whether Respondent should continue practicing without the need of a monitor. The report shall be submitted to the Board or its designee within 30 calendar days before the end of the third year of probation.

In lieu of a monitor, Respondent may participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation.

4. PROHIBITED PRACTICE. During Probation, Respondent is prohibited from treating persistent chlamydia pneumoniae infection and chronic human herpes virus 6, and will refer such patients to a specialist. During probation, Respondent is prohibited from treating any patient by intravenous antibiotics and antiviral agents, and intramuscular injections of antibiotics and antivirals. Respondent is further prohibited during probation from treating any patient receiving intravenous and intramuscular injections of antibiotics or antivirals, except where the treatment is ordered and managed by another physician. Respondent will not place or use a PICC line with any patient.

After the effective date of the Decision, all patients being treated by Respondent for a persistent infection by intravenous antibiotics and intramuscular injections of antibiotics, including but not limited to chlamydia pneumoniae infection and chronic human herpes virus 6 shall be notified by Respondent that Respondent is prohibited from treating any patient by intravenous antibiotics and intramuscular injections of antibiotics, and from treating any patients with persistent chlamydia pneumoniae infection and chronic human herpes virus 6, except when under the care of another specialist. Any new patient to be treated with an antibiotic or antiviral

shall be provided with this notification at the time of their initial appointment.

Respondent shall maintain a log of all patients to whom the required oral notification was made. The log shall contain the: 1) patient's name, address and phone number; 2) patient's medical record number, if available; 3) the full name of the person making the notification; 4) the date the notification was made; and 5) a description of the notification given. Respondent shall keep this log in a separate file or ledger, in chronological order, shall make the log available for immediate inspection and copying on the premises at all times during business hours by the Board or its designee, and shall retain the log for the entire term of probation.

5. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

6. SUPERVISION OF PHYSICIAN ASSISTANTS. During probation, Respondent is prohibited from supervising physician assistants.

7. OBEY ALL LAWS. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

8. QUARTERLY DECLARATIONS. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

9. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit and all terms and conditions of this Decision.

Address Changes

Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Place of Practice

Respondent shall not engage in the practice of medicine in Respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal

Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

In the event Respondent should leave the State of California to reside or to practice Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

10. INTERVIEW WITH THE BOARD OR ITS DESIGNEE. Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

11. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than

30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine in California as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete a clinical training program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; and General Probation Requirements.

12. COMPLETION OF PROBATION. Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

13. VIOLATION OF PROBATION. Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until

the matter is final.

14. LICENSE SURRENDER. Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his or her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

15. PROBATION MONITORING COSTS. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Thomas E. Still. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 8/27/2015

LARRY DAVID RESNECK-SANNES, M.D.
Respondent

I have read and fully discussed with Respondent Larry David Resneck-Sannes, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 8/27/2015

Thomas E. Still
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California.

Dated:

Respectfully submitted,

KAMALA D. HARRIS
Attorney General of California
JOSE R. GUERRERO
Supervising Deputy Attorney General

EMILY L. BRINKMAN
Deputy Attorney General
Attorneys for Complainant

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DATED: _____

_____
Thomas E. Still
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California.

Dated: 8/28/2015

Respectfully submitted,

KAMALA D. HARRIS
Attorney General of California
JOSE R. GUERRERO
Supervising Deputy Attorney General

EMILY L. BRINKMAN
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 03-2012-222584

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Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **LARRY RESNECK-SANNES, M.D.** 5403 Scotts Valley Drive, #A Scotts Valley, California 95066 Physician's & Surgeon's Certificate No. G 25952 Respondent.	Case No. 03-2012-222584 **ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer ("Complainant") brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California ("Board").

2. On November 1, 1973, the Medical Board of California issued Physician's and Surgeon's certificate Number G 25952 to Larry Resneck-Sannes, M.D. ("Respondent"). The Physician's and Surgeon's certificate was in full force and effect at all times relevant to the charges brought herein and will expire on July 31, 2015, unless renewed.

JURISDICTION

3. This Accusation is brought before the Medical Board of California, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2227 of the Code provides, in pertinent part, that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked or suspended for a period not to exceed one year.

5. Section 2234 of the Code provides in pertinent part that the Board "shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating . . . any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

" . . . ."

6. Section 2266 of the Code provides that "[t]he failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

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FACTS

PATIENT P-1[1]

7. Respondent reports that in 2009, Patient P-1, currently 60 years old, had been his patient for nineteen years. According to Respondent, P-1 presented in mid-2009 complaining of "dramatic fatigue."

8. Respondent saw P-1 on April 14, 2009. The physical examination is reflected only by a weight and various checkmarks on a pre-printed page and the chart notes reflect left upper chest pain, left tennis elbow, elevated cholesterol. There is no impression and no recommendations. Respondent ordered a Complete Blood Count ("CBC") and a standard comprehensive panel of blood tests and a urine test for P-1 but did not document ordering the tests. The test results were negative.

9. P-1's next visit with Respondent was on October 14, 2009. Except for an entry for weight, there is no physical examination documented. The chart reflects that P-1 complained of one year of poor sleep and pessimism and that Respondent discussed talk therapy and prescribed an antidepressant and Zithromax Z-Pak[2] for sinusitis.

10. P-1 returned on October 28, 2009 complaining of headache and fatigue. Respondent ordered tests for chlamydia pneumoniae and human herpes virus 6 ("HHV 6"). The tests reflected elevated antibody titers to both of these organisms. These tests were repeated periodically throughout Respondent's treatment of P-1.

11. At P-1's next visit, in November 2009, Respondent diagnosed P-1 with chronic fatigue syndrome and started him on oral Biaxin[3] for chlamydia pneumoniae infection. There is no documentation of the basis for concluding that P-1 had a chlamydia pneumoniae infection. Respondent did not refer P-1 to a neurological or infectious disease specialist for evaluation.

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[1] The patients are designated in this document as Patients P-1 through P-5 to protect their privacy. Respondent knows the names of the patients and can confirm their identity through discovery.

[2] Zithromax Z-Pak is a trade name for azithromycin, a macrolide antibiotic.

[3] Biaxin is a trade name for clarithromycin, a macrolide antibiotic.

12. P-1 continued taking Biaxin until July 2010 and then stopped until November 2010. On November 10, 2010, without any indication of a physical examination, Respondent restarted P-1 on Biaxin. Respondent described P-1's complaints as poor sleep, anxiety, erectile dysfunction, lack of concentration, and mild headaches. He entered a diagnosis in P-1's chart of chronic fatigue syndrome and pneumonia due to chlamydia. Again, there was no documentation of the basis for these diagnoses.

13. On March 7, 2011, Respondent entered a diagnosis in P-1's chart notes of HHV 6 encephalitis and noted that he was considering adding Famvir[4] for the HHV 6 and intravenous antibiotics. Respondent did not document his reasoning in diagnosing P-1 with HHV 6 encephalitis.

14. The chart note for P-1's April 2, 2011 visit, reflects that the reason for the visit was fatigue. Respondent noted symptoms of mental clouding, left arm numbness when lying down, and some back pain. There is no documentation of a neurological examination despite these symptoms. The only components of a physical examination documented are weight and blood pressure. Respondent noted that P-1 continued to take antibiotics and concluded "consider chronic injections."

15. On April 18, 2011, Respondent discontinued P-1's Biaxin and started him on two intravenous antibiotics approximately three times a week. Over the next several months, P-1 had twenty-seven injections of cefuroxime[5] and twenty-eight of doxycycline.[6] His last injections in the series were on July 7, 2011. On January 9, 2012, Respondent started daily intramuscular injections of cefuroxime and gentamicin[7] which were reduced to five times a week and three times a week, respectively, on January 13, 2012.

16. Respondent maintained chart notes for approximately thirty-eight visits with P-1 between April 14, 2009 and January 27, 2012. During that time, he never documented a full

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[4] Famvir is a trade name for famciclovir and is an antiviral medication used to treat herpes infections.

[5] Cefuroxime is a cephalosporin antibiotic.

[6] Doxycycline is a tetracycline antibiotic.

[7] Gentamicin is an aminoglycoside antibiotic.

physical examination and only once or twice documented even a partial physical examination. He documented partial vital signs on ten visits. Clinical comments, impressions, and plans were absent in many of his follow up visits. He never documented a basis for his diagnoses. There is no documentation that a discussion of the risks and benefits of treatment was given.

17. Respondent did not refer P-1 to a neurologist, infectious disease specialist, or other specialist during the time he was diagnosed with chlamydia pneumonia infection and HHV 6 encephalitis and was being treated for such neurological symptoms as depression, anxiety, mental clouding, arm numbness, headaches, and blurry vision.

FIRST CAUSE FOR DISCIPLINE
(Gross Negligence; Inadequate Documentation)

18. Respondent's license is subject to disciplinary action for unprofessional conduct in violation of section 2234, subdivisions (a) (violating provisions of this chapter) and (b) (gross negligence), and section 2266 (inadequate documentation) in that he did not perform a complete physical examination on Patient P-1 during the period at issue, did not perform a neurological examination despite P-1's many neurological/psychological complaints, and he did not maintain accurate, adequate, and complete records for Patient P-1, as described above, including documentation of appropriate physical examinations.

SECOND CAUSE FOR DISCIPLINE
(Gross Negligence)

19. Respondent's license is subject to disciplinary action for unprofessional conduct in violation of section 2234, subdivisions (a) (violating provisions of this chapter) and (b) (gross negligence), in that he diagnosed Patient P-1 with a chronic chlamydia pneumonae infection despite P-1's having no symptoms consistent with such an infection and despite Respondent's making no referrals to confirm the diagnosis, failing to order appropriate testing to substantiate the diagnosis, and treating P-1 for this infection for extended periods of time with oral, intramuscular, and intravenous antibiotics thus exposing him to potential toxicities and future antibiotic resistance.

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THIRD CAUSE FOR DISCIPLINE
(Gross Negligence)

20. Respondent's license is subject to disciplinary action for unprofessional conduct in violation of section 2234, subdivisions (a) (violating provisions of this chapter) and (b) (gross negligence), in that he diagnosed Patient P-1 with HHV 6 encephalitis without a basis for such a diagnosis and provided him with treatment that was not based on scientific information or evidence based medicine.

PATIENT P-2

21. Respondent reports that Patient P-2, currently 67 years old, has been his patient since he first started practice.

22. Without documenting a reason, Respondent ordered tests for chlamydia pneumoniae and HHV 6 for P-2. The tests were performed on December 7, 2009 and reflected elevated antibody titers to both of these organisms. These tests were repeated periodically throughout Respondent's treatment of P-2.

23. In February 2009, P-2 had a lumbar laminectomy. Respondent wrote in P-2's December 21, 2009 chart note that she had had chronic fatigue since the surgery and, without a physical examination, diagnosed her with chronic fatigue syndrome despite not mentioning fatigue in any of the chart notes for the six previous post-surgery visits. On P-2's next visit on December 29, 2009, again without a physical examination, Respondent noted "chronic illness" citing HHV and chlamydia pneumoniae.

24. On January 5, 2010, without a physical examination, without explanation, and without a plan, Respondent started P-2 on oral doxycycline.

25. On March 15, 2010 P-2 was seen for fatigue. At that time she was on doxycycline and Valcyte[8] for pain and chronic fatigue. On May 19, 2010, Respondent stopped all medications; on July 29, 2010, he re-instituted and increased the amount of Valcyte and added Famvir, another antiviral medication; and on November 22, 2010, he re-started doxycycline.

[8] Valcyte is a trade name for valganciclovir hydrochloride. It is an antiviral medication whose standard use is to treat cytomegalovirus retinitis.

26. On December 14, 2010, without a physical examination or explanation, Respondent started P-2 on intravenous Rocephin. Her diagnosis was pneumonia due to chlamydia.

27. On December 22, 2010, Respondent switched P-2 from Rocephin to intravenous cefuroxime three times a week and continued the Valcyte. Her diagnoses were pneumonia due to chlamydia and HHV 6 encephalitis.

28. On March 1, 2011, Respondent discontinued Valcyte and continued the intravenous cefuroxime treatment two times a week. On March 4, without a physical examination or any indication or reasoning, Respondent re-started P-2 on Valcyte. On March 17, 2011, Respondent's chart notes indicate that P-2 was continuing with Valcyte. Two weeks later, on March 30, 2011 Respondent noted that P-2 had been off Valcyte for two months and her HHV 6 titers had increased. On March 30, without a physical examination, he documented a resumption of Valcyte, the addition of acyclovir,[9] and a hold on antibiotic injections while he focused on HHV 6. Twelve days after this, on April 12, 2011, Respondent documented that P-2 had been off Valcyte for three months.

29. On August 10, 2011, Respondent noted that he was re-starting P-2 on intravenous antibiotics since her pain and fatigue had returned with a strong intensity. He treated her with intravenous cerfuroxine three times a week through September 2, 2011 when he added intravenous doxycycline. He resumed Valcyte on August 31, 2011.

30. On September 23, 2011, Respondent noted that P-2 had tenderness and discoloration at the injections sites on both her arms. On September 29, 2011, P-2 had a peripherally inserted central catheter ("PICC") line[10] placed. Injections of cefuroxime and doxycycline were continued three times a week until December 30, 2011 when the frequency was documented to be reduced to two times a week. Intramuscular injections of gentamicin were

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[9] Acyclovir is in a class of antiviral medications called synthetic nucleoside analogues. It is prescribed to stop the spread of the herpes virus in the body

[10] A PICC is inserted in a peripheral vein in the arm and advanced proximally toward the heart through increasingly larger veins until the catheter tip terminates in a large vein in the chest near the heart to obtain intravenous access. It is a form of intravenous access that can be used for a prolonged period of time.

added at the same frequency on November 18, 2011 without explanation and without a physical examination.

31. Respondent maintained chart notes for over one hundred visits with P-1 between January 8, 2009 and February 6, 2012. During that time, he documented a physical examination on December 30, 2011 and otherwise only once or twice documented even a partial physical examination. He frequently failed to document vital signs. Clinical comments, impressions, and plans were absent in many of his follow up visits. He never documented a basis for his diagnoses. There is no documentation that a discussion of the risks and benefits of treatment was given.

32. Respondent did not refer P-2 to a psychologist, psychiatrist, or infectious disease specialist to address such symptoms as depression, mental confusion, and diagnoses of chlamydia pneumonia infection and HHV 6.

FOURTH CAUSE FOR DISCIPLINE
(Gross Negligence; Inadequate Documentation)

33. Respondent's license is subject to disciplinary action for unprofessional conduct in violation of section 2234, subdivisions (a) (violating provisions of this chapter) and (b) (gross negligence), and section 2266 (inadequate documentation) in that Respondent saw P-2 multiple times over a three year period with only one physical examination and did not maintain accurate, adequate, and complete records for Patient P-2 including documentation of history and physical examinations, assessments, and plans, as described above.

FIFTH CAUSE FOR DISCIPLINE
(Gross Negligence)

34. Respondent's license is subject to disciplinary action for unprofessional conduct in violation of section 2234, subdivisions (a) (violating provisions of this chapter) and (b) (gross negligence), in that he diagnosed Patient P-2 with a chronic chlamydia pneumonae infection despite P-2's having no symptoms consistent with such an infection and Respondent's making no referrals to confirm the diagnosis, failing to order appropriate testing to substantiate the diagnosis,

and treating her for this infection for extended periods of time with oral, intramuscular, and intravenous antibiotics thus exposing her to potential toxicities and future antibiotic resistance.

SIXTH CAUSE FOR DISCIPLINE
(Gross Negligence)

35. Respondent's license is subject to disciplinary action for unprofessional conduct in violation of section 2234, subdivisions (a) (violating provisions of this chapter) and (b) (gross negligence), in that he diagnosed Patient P-2 with HHV 6 encephalitis without a basis for such a diagnosis.

PATIENT P-3

36. Respondent reports that in 2003, Patient P-3, currently 64 years old, suddenly became sick. She was unable to think clearly, slept poorly, had disabling body pain, and had intermittent body rashes. He says that he first saw P-3 in August 2006. He had tests done for chlamydia pneumoniae and Ehrlichiosis, a tickborne bacterial infection, which reflected elevated antibody titers to both of these organisms. Based on the elevated titers, he treated her with oral azithromycin and doxycycline for approximately one month. When she could no longer tolerate the oral antibiotics, he treated her for a month with intravenous azithromycin using a PICC line. Tests for chlamydia pneumoniae were repeated periodically throughout Respondent's treatment of P-3. P-3 had normal chest x-rays in 2007, 2008, and 2009.

37. After the month of intravenous antibiotics, Respondent prescribed oral azithromycin for P-3.

38. In 2007 or 2008, P-3 had a hysterectomy. After the surgery, he resumed treating her for chlamydia pneumoniae with antibiotics. He gave her intramuscular shots of ampicillin[11] and gentamicin three times a week. This continued for two months followed by a period off of antibiotics and another two and a half months of intramuscular ampicillin and gentamicin.

39. When Respondent saw P-3 on March 4, 2010, he decided to restart intravenous antibiotics "although doing very well." There is no physical examination reflected and no

[11] Ampicillin is an aminoglycoside antibiotic.

explanation of why he restarted the antibiotic treatment. The only other chart notation is that P-3 had sudden sebborrheikerratosis [*sic*] on her left wrist. There is no impression and no recommendations other than to restart the antibiotic.

40. P-3's next visit with Respondent was on May 17, 2010. The reason for the visit is knee pain. There is no physical examination documented, no impression, and no plan. Respondent's diagnosis was sarcoidosis. He queried whether the knee pain was from mechanical damage or arthritis due to chlamydia pneumoniae.

41. In his June 17, 2010 chart notes, Respondent identified the reason for the visit as P-3's having just returned from a cruise. He noted that she had muscle spasms and stress but in general felt better and that she was seeing a physician the following week for knee and hip problems. There is no physical examination documented and no vital signs or review of systems. The diagnosis was chronic fatigue syndrome, the assessment was intravenous Rocephin,[12] and the plan was for metformin[13]–although P-3's glucose levels were within the normal reference range—and laboratory tests for chlamydia pneumoniae and C-reactive protein. There was no reason given for the antibiotic, for the metformin, or for ordering the laboratory tests. Respondent stated that he discontinued the Metformin after a short period because there were too many side effects.

42. Respondent continued giving P-3 intravenous Rocephin over the next several visits. On July 6, 2010, he noted that she had continuing fatigue and that she was not improving with Rocephin. He gave her intramuscular shots of Rocephin and gentamicin at that visit. No physical examination is documented and no clinical reasoning reflected. Respondent did not refer P-3 to a neurological or infectious disease specialist for evaluation.

43. On July 27, 2010, Respondent wrote that P-3 had more brain fog off antibiotics. He noted that P-3's face had been itchy, that she had had vertigo, and that one night she had a racing heart and shortness of breath for a few minutes. He did not document a physical

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[12] Rocephin is a trade name ceftriaxone, a cephalosporin antibiotic.

[13] Metformin is an oral antidiabetic drug in the biguanide class. It is the first-line drug of choice for the treatment of type 2 diabetes. A rare side effect of Metformin is a serious, life-threatening condition called lactic acidosis.

examination or vital signs. He noted that P-3 had a clot and pain from IV doses of doxycycline and Rocephin and could not take rifampin.[14] He started her on oral doxycycline and Cipro.[15]

44. On August 3, 2010, Respondent noted that P-3's symptoms had worsened and that she was due to start hyperbaric oxygen treatment the following week. Her next visit was April 1, 2011 after completing the hyperbaric oxygen treatment. The only chart note on that date is that she was feeling much better. No physical examination or vital signs were documented.

45. Although it is not clear from the chart notes, Respondent states that P-3 was not treated with antibiotics after June 2011.

46. On December 29, 2011, Respondent diagnosed P-3 with HHV 6 encephalitis without documenting a basis for the diagnosis. The only symptoms documented are nausea, rapid satiation, memory problems, and difficulty preparing dinner.

47. For the 16 visits from March 4, 2010 through December 29, 2011, Respondent never documented a full physical examination of P-3 and rarely documented vital signs. Clinical comments, impressions, and plans were absent in many of his visits. He never documented a basis for his diagnoses. There is no documentation that a discussion of the risks and benefits of treatment was given.

48. Respondent did not refer P-3 to a neurologist, infectious disease specialist, or other relevant specialist during the time she was diagnosed with chlamydia pneumonia and HHV 6 encephalitis and was being treated for such neurological symptoms as mental clouding and inability to think clearly.

SEVENTH CAUSE FOR DISCIPLINE
(Gross Negligence; Inadequate Documentation)

49. Respondent's license is subject to disciplinary action for unprofessional conduct in violation of section 2234, subdivisions (a) (violating provisions of this chapter) and (b) (gross negligence), and section 2266 (inadequate documentation) in that he did not perform a complete physical examination on Patient P-3 during the period at issue, and he did not maintain accurate,

[14] Rifampin is in the antimycobacterial class of medications.
[15] Cipro is a trade name for ciprofloxacin, a fluoroquinolone antibiotic.

adequate, and complete records for Patient P-3 including documentation of appropriate physical examinations, as described above.

EIGHTH CAUSE FOR DISCIPLINE
(Gross Negligence)

50. Respondent's license is subject to disciplinary action for unprofessional conduct in violation of section 2234, subdivisions (a) (violating provisions of this chapter) and (b) (gross negligence), in that he diagnosed Patient P-3 with a chronic chlamydia pneumonae infection despite P-3's having no symptoms consistent with such an infection and Respondent's making no referrals to confirm the diagnosis, failing to order appropriate testing to substantiate the diagnosis, and treating her for this infection for extended periods of time with oral, intramuscular, and intravenous antibiotics thus exposing her to potential toxicities and future antibiotic resistance.

NINTH CAUSE FOR DISCIPLINE
(Gross Negligence)

51. Respondent's license is subject to disciplinary action for unprofessional conduct in violation of section 2234, subdivisions (a) (violating provisions of this chapter) and (b) (gross negligence), in that he diagnosed Patient P-3 with HHV 6 encephalitis without a basis for such a diagnosis.

TENTH CAUSE FOR DISCIPLINE
(Repeated Negligent Acts)

52. Respondent's license is subject to disciplinary action for unprofessional conduct in violation of section 2234, subdivisions (a) (violating provisions of this chapter) and (c) (repeated negligent acts), in that he engaged in the conduct set out in the First through Ninth and the Eleventh through Thirteenth Causes for Discipline and prescribed metformin for Patient P-3 with no basis and despite potential side effects.

PATIENT P-4

53. Respondent saw Patient P-4, currently 64 years old, eighteen times from January 12, 2009 through February 13, 2012.

54. During that time, Respondent never documented a full physical examination of P-4 and clinical comments, impressions, and plans were absent in many of his visits. He rarely documented a basis for his diagnoses. There is no documentation that a discussion of the risks and benefits of treatment was given.

55. On April 30, 2009, Respondent gave P-4 diagnoses of menopausal disorder NOS and Obesity. He noted a history of high blood pressure and something illegible having to do with diabetes. He prescribed Janumet,[16] a medication used to treat type 2 diabetes although P-4's most recent blood glucose level from a sample taken on April 3, 2009 was normal. Although P-4 never had a blood glucose level or hemoglobin A1C level reflecting diabetes, he prescribed the medication for six months, stopped for six months, and resumed prescribing it in May 2010 for five more months (May, June, July, September, and November 2010).

ELEVENTH CAUSE FOR DISCIPLINE
(Gross Negligence; Inadequate Documentation)

56. Respondent's license is subject to disciplinary action for unprofessional conduct in violation of section 2234, subdivisions (a) (violating provisions of this chapter) and (b) (gross negligence), and section 2266 (inadequate documentation) in that he did not perform a complete physical examination on Patient P-4 during the period at issue, and he did not maintain accurate, adequate, and complete records for Patient P-4 including, among other things, documentation of appropriate physical examinations and pertinent and clear historical information, assessment, and treatment plans, as described above.

TWELFTH CAUSE FOR DISCIPLINE
(Gross Negligence)

57. Respondent's license is subject to disciplinary action for unprofessional conduct in violation of section 2234, subdivisions (a) (violating provisions of this chapter) and (b) (gross

[16] Janumet is a prescription medicine that contains two prescription diabetes medicines, sitagliptin and metformin. It is used to treat type 2 diabetes. A rare side effect of Metformin is a serious, life-threatening condition called lactic acidosis.

negligence), in that he prescribed Janumet for Patient P-4 with no basis and despite potential side effects.

PATIENT P-5

58. Patient P-5, currently 54 years old, was a complicated patient with a history of antiphospholipid syndrome, strokes, chronic kidney disease, seizure disorder, hypertension, and hypersensitivity pneumonitis. Respondent saw P-5 nineteen times from June 9, 2010 through November 1, 2011.

59. During that time, Respondent did not document physical examinations, physical examination findings, vital signs, and even relevant historical information on the majority of P-5's clinic visits. On April 19, 2011, for example, Respondent started P-5 on a series of five Ferrlecit[17] injections without documenting a physical examination, giving a reason for the injections, or documenting having obtained informed consent. He also gave P-5 an injection of adrenocorticotropic hormone[18] ("ACTH") without documenting the reason. On May 5, 2011, Respondent extended the number of Ferrlecit injections to ten without documenting a physical examination or reason for the additional injections. On February 1, 2011 Respondent diagnosed P-5 with rheumatoid lung without documenting a basis for the diagnosis and on June 24, 2011, diagnosed him with rheumatoid arthritis without any laboratory studies or explanation for the diagnosis.

60. The records do not include a single visit with a complete history, physical examination, assessment, and plan. There is no documentation that a discussion of the risks and benefits of treatment was given.

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[17] Ferrlecit, a trade name for sodium ferric gluconate complex in sucrose for injection, is an intravenous iron replacement product for the treatment of iron deficiency anemia with chronic kidney disease receiving chronic hemodialysis and supplemental epoetin therapy.

[18] Adrenocorticotropic hormone ("ACTH") is a polypeptide tropic hormone produced and secreted by the anterior pituitary gland. As an injectable medication, it is used to treat such things as multiple sclerosis, lupus, and rheumatoid arthritis.

THIRTEENTH CAUSE FOR DISCIPLINE
(Gross Negligence; Inadequate Documentation)

61. Respondent's license is subject to disciplinary action for unprofessional conduct in violation of section 2234, subdivisions (a) (violating provisions of this chapter) and (b) (gross negligence), and section 2266 (inadequate documentation) in that he did not perform a complete physical examination on Patient P-5 during the period at issue, and he did not maintain accurate, adequate, and complete records for Patient P-5 including, among other things, documentation of appropriate physical examinations and pertinent and clear historical information, assessment, and treatment plans, as described above.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 25952 issued to Larry Resneck-Sannes, M.D.;

2. Revoking, suspending, or denying approval of Larry Resneck-Sannes, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code;

3. Ordering Larry Resneck-Sannes, M.D., if placed on probation, to pay the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: June 5, 2014

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
State of California
Complainant